

1.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06141

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, striking the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Please 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1.		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
FOR STATE HEALTH DEPT.		Reg. Dist. No.													
		1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)								
6172 Talbot					a. STATE Maryland										
M 08		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
												Near Tilghman, Md.		Near Mt. Rainer	
08		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		3205 Vernum St.		d. DATE OF DEATH		May 24 1958					
												Stanley Hartman Avery		3205 Vernum St.	
1.		3. NAME OF DECEASED (Type or print)		First		Middle		Month		Day		Year			
														Stanley	
2.		5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years from birthday) 24 yrs.		IF UNDER 1YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
3.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		Address		USA			
														Jalousie Opr.	
4.		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		INTERVAL BETWEEN ONSET AND DEATH	
5.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. BURIAL, CREMATION, REMOVAL (Specify) Burial		23. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.	
6.		20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Talbot		(County) Talbot		(State) Md.			
														20c. TIME OF INJURY Month, Day, Year 19	
7.		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. BURIAL, CREMATION, REMOVAL (Specify) Burial		23. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		24. REC'D BY REGISTRAR JUN 4 '58		25. REGISTRAR'S SIGNATURE A. DeLoach		DATE SIGNED 30 May '58			
														21. ACTUAL SIGNATURE Thurston H. Davis	
8.		24. REC'D BY REGISTRAR JUN 4 '58		25. REGISTRAR'S SIGNATURE A. DeLoach		26. ADDRESS ADDRESS		27. LOCATION (City, town, or county) Arlington, Va.		28. DATE SIGNED 30 May '58					
												24. REC'D BY REGISTRAR JUN 4 '58		25. REGISTRAR'S SIGNATURE A. DeLoach	
9.		26. ADDRESS ADDRESS		27. LOCATION (City, town, or county) Arlington, Va.		28. DATE SIGNED 30 May '58									
								26. ADDRESS ADDRESS		27. LOCATION (City, town, or county) Arlington, Va.		28. DATE SIGNED 30 May '58			
10.		29. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		30. ADDRESS ADDRESS		31. LOCATION (City, town, or county) Arlington, Va.		32. DATE SIGNED 30 May '58							
										29. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		30. ADDRESS ADDRESS		31. LOCATION (City, town, or county) Arlington, Va.	
11.		33. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		34. ADDRESS ADDRESS		35. LOCATION (City, town, or county) Arlington, Va.		36. DATE SIGNED 30 May '58							
										33. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		34. ADDRESS ADDRESS		35. LOCATION (City, town, or county) Arlington, Va.	
12.		37. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		38. ADDRESS ADDRESS		39. LOCATION (City, town, or county) Arlington, Va.		40. DATE SIGNED 30 May '58							
										37. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		38. ADDRESS ADDRESS		39. LOCATION (City, town, or county) Arlington, Va.	
13.		41. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		42. ADDRESS ADDRESS		43. LOCATION (City, town, or county) Arlington, Va.		44. DATE SIGNED 30 May '58							
										41. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		42. ADDRESS ADDRESS		43. LOCATION (City, town, or county) Arlington, Va.	
14.		45. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		46. ADDRESS ADDRESS		47. LOCATION (City, town, or county) Arlington, Va.		48. DATE SIGNED 30 May '58							
										45. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		46. ADDRESS ADDRESS		47. LOCATION (City, town, or county) Arlington, Va.	
15.		49. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		50. ADDRESS ADDRESS		51. LOCATION (City, town, or county) Arlington, Va.		52. DATE SIGNED 30 May '58							
										49. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		50. ADDRESS ADDRESS		51. LOCATION (City, town, or county) Arlington, Va.	
16.		53. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		54. ADDRESS ADDRESS		55. LOCATION (City, town, or county) Arlington, Va.		56. DATE SIGNED 30 May '58							
										53. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		54. ADDRESS ADDRESS		55. LOCATION (City, town, or county) Arlington, Va.	
17.		57. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		58. ADDRESS ADDRESS		59. LOCATION (City, town, or county) Arlington, Va.		60. DATE SIGNED 30 May '58							
										57. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		58. ADDRESS ADDRESS		59. LOCATION (City, town, or county) Arlington, Va.	
18.		61. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		62. ADDRESS ADDRESS		63. LOCATION (City, town, or county) Arlington, Va.		64. DATE SIGNED 30 May '58							
										61. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		62. ADDRESS ADDRESS		63. LOCATION (City, town, or county) Arlington, Va.	
19.		65. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		66. ADDRESS ADDRESS		67. LOCATION (City, town, or county) Arlington, Va.		68. DATE SIGNED 30 May '58							
										65. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		66. ADDRESS ADDRESS		67. LOCATION (City, town, or county) Arlington, Va.	
20.		69. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		70. ADDRESS ADDRESS		71. LOCATION (City, town, or county) Arlington, Va.		72. DATE SIGNED 30 May '58							
										69. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		70. ADDRESS ADDRESS		71. LOCATION (City, town, or county) Arlington, Va.	
21.		73. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		74. ADDRESS ADDRESS		75. LOCATION (City, town, or county) Arlington, Va.		76. DATE SIGNED 30 May '58							
										73. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		74. ADDRESS ADDRESS		75. LOCATION (City, town, or county) Arlington, Va.	
22.		77. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		78. ADDRESS ADDRESS		79. LOCATION (City, town, or county) Arlington, Va.		80. DATE SIGNED 30 May '58							
										77. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		78. ADDRESS ADDRESS		79. LOCATION (City, town, or county) Arlington, Va.	
23.		81. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		82. ADDRESS ADDRESS		83. LOCATION (City, town, or county) Arlington, Va.		84. DATE SIGNED 30 May '58							
										81. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		82. ADDRESS ADDRESS		83. LOCATION (City, town, or county) Arlington, Va.	
24.		85. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		86. ADDRESS ADDRESS		87. LOCATION (City, town, or county) Arlington, Va.		88. DATE SIGNED 30 May '58							
										85. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		86. ADDRESS ADDRESS		87. LOCATION (City, town, or county) Arlington, Va.	
25.		89. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		90. ADDRESS ADDRESS		91. LOCATION (City, town, or county) Arlington, Va.		92. DATE SIGNED 30 May '58							
										89. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		90. ADDRESS ADDRESS		91. LOCATION (City, town, or county) Arlington, Va.	
26.		93. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		94. ADDRESS ADDRESS		95. LOCATION (City, town, or county) Arlington, Va.		96. DATE SIGNED 30 May '58							
										93. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		94. ADDRESS ADDRESS		95. LOCATION (City, town, or county) Arlington, Va.	
27.		97. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		98. ADDRESS ADDRESS		99. LOCATION (City, town, or county) Arlington, Va.		100. DATE SIGNED 30 May '58							
										97. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		98. ADDRESS ADDRESS		99. LOCATION (City, town, or county) Arlington, Va.	
28.		101. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		102. ADDRESS ADDRESS		103. LOCATION (City, town, or county) Arlington, Va.		104. DATE SIGNED 30 May '58							
										101. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		102. ADDRESS ADDRESS		103. LOCATION (City, town, or county) Arlington, Va.	
29.		105. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		106. ADDRESS ADDRESS		107. LOCATION (City, town, or county) Arlington, Va.		108. DATE SIGNED 30 May '58							
										105. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		106. ADDRESS ADDRESS		107. LOCATION (City, town, or county) Arlington, Va.	
30.		109. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		110. ADDRESS ADDRESS		111. LOCATION (City, town, or county) Arlington, Va.		112. DATE SIGNED 30 May '58							
										109. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		110. ADDRESS ADDRESS		111. LOCATION (City, town, or county) Arlington, Va.	
31.		113. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		114. ADDRESS ADDRESS		115. LOCATION (City, town, or county) Arlington, Va.		116. DATE SIGNED 30 May '58							
										113. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		114. ADDRESS ADDRESS		115. LOCATION (City, town, or county) Arlington, Va.	
32.		117. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		118. ADDRESS ADDRESS		119. LOCATION (City, town, or county) Arlington, Va.		120. DATE SIGNED 30 May '58							
										117. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael's Mort.		118. ADDRESS ADDRESS		119. LOCATION (City, town, or county) Arlington, Va.	

THE HISTORICAL LIBRARY OF THE UNIVERSITY OF TORONTO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6151 CERTIFICATE OF DEATH

06142

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Talbot		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Easton		c. LENGTH OF STAY IN 1b 20 mi.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Tunis Mills.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easton Memorial Hospital		d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Anna Rebecca Bailey		First	Middle	Last	4. DATE OF DEATH May 27, 1958	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Oct 14, 1881	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Talbot County, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John H. Bailey		14. MOTHER'S MAIDEN NAME Clara Tufford						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT John H. Bailey, Tunis Mills, Md		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		DUE TO Arteriosclerotic heart disease				INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) DUE TO						
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Talbot County, Md		(County)		(State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M, from the causes and on the date stated above. ACTUAL SIGNATURE Lewis Whetby		M.D.		ADDRESS (Street, city or town, state) Talbot Md		DATE SIGNED 5-24-58		
PHYSICIAN'S NAME (Type) NELTY								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 30, 58		22c. NAME OF CEMETERY OR CREMATORIAL Spring Hill		22d. LOCATION (City, town, or county) Easton, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE C. J. Whetby		ADDRESS Talbot Md.		24a. REC'D BY REGISTRAR JUN 2 1958		24b. REGISTRAR'S SIGNATURE John Whetby		
VS A15 (4) 15M 9/55								

1 - 100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6173 CERTIFICATE OF DEATH

Reg. Dist. No. 06143

1. PLACE OF DEATH a. COUNTY Talbot Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Talbot Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe Md.		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe Md.		d. STREET ADDRESS Trappe Md.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Trappe Md.				d. STREET ADDRESS Trappe Md.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Attison		First	Middle	Last	4. DATE OF DEATH May	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 8/4/1913		9. AGE (In years lost birthday) 41 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Trappe Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Samuel O. Barnes				14. MOTHER'S MAIDEN NAME Mary Price				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-32-6366		17. INFORMANT Mrs. Attison Barnes		Address Trappe Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 145.0		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		Metastatic carcinoma of neck		INTERVAL BETWEEN ONSET AND DEATH 3 mo.		
		DUE TO (c)		Carcinoma of Tonsil, rt		6 mo.		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cambridge		(County) (State)
21. I certify that I attended the deceased from Sept 1958, 19, to Dec. 13, 1958, that I last saw the deceased alive on May 12, 1958, and that death occurred at 6 A.M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Cambridge		DATE SIGNED Arthur B. Cecil, Jr.
ACTUAL SIGNATURE ARTHUR B. CECIL, JR.		PHYSICIAN'S NAME (Type) ARTHUR B. CECIL, JR.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/16/58		22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park		22d. LOCATION (City, town, or county) Cambridge		(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR DATE MAY 19 '58		24b. REGISTRAR'S SIGNATURE LeCompte		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: Enter this certificate has been signed by the attending physician and completely filled in by the funeral director.
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6152 CERTIFICATE OF DEATH

06144

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Lucen Anne</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>2 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Centreville</i>		d. STREET ADDRESS <i>17 X-2</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hosp.</i>				d. STREET ADDRESS <i>?</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>George Henry Baynard</i>		First	Middle	Lost	4. DATE OF DEATH <i>May 23 1958</i>	Month	Day	Year
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Not given</i>	9. AGE (In years last birthday) <i>54 yrs.</i>	10. UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Barber</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Fred Baynard</i>		14. MOTHER'S MAIDEN NAME <i>Rosetta Hayman</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Not known</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Helen T. Ayers</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>581.0</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		DUE TO <i>Cirrhosis of liver</i>		DUE TO <i>Sarcoma of right thigh</i>		INTERVAL BETWEEN ONSET AND DEATH		
DUE TO <i>?</i>		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>M.D.</i>		(County) <i>2195 Washington St.</i> (State) <i>Baltimore</i>
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____, from the causes and on the date stated above.								ADDRESS (Street, city or town, state) <i>2195 Washington St. Baltimore</i>
ACTUAL SIGNATURE <i>E.C. H. Schmidt</i>								DATE SIGNED <i>27 May 58</i>
PHYSICIAN'S NAME (Type) <i>E.C. H. Schmidt</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>5/26/58</i>		22b. DATE THEREOF <i>5/26/58</i>		22c. NAME OF CEMETERY OR Crematory <i>Chesterville Cemetery</i>		22d. LOCATION (City, town, or county) <i>Centerville Md.</i>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>James B. Dashiell</i>		ADDRESS <i>Easton Md.</i>		24a. REC'D BY REGISTRAR <i>1</i>		24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>		
				DATE <i>MAY 29 '58</i>				

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6174

CERTIFICATE OF DEATH

06145

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe		c. LENGTH OF STAY IN 1b 1 month	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Grimm Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown ✓ 14372	
3. NAME OF DECEASED (Type or print) Norris C. Crew		d. STREET ADDRESS Cross	
4. DATE OF DEATH May 26, 1958		Month May	Day 26
5. SEX Male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Oct. 1, 1884		9. AGE (In years last birthday) 73 yrs.	10. IF UNDER 1 YEAR Months 0
11. BIRTHPLACE (State or foreign country) Maryland		12. IF UNDER 24 HRS. Days 0	13. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Poultry Dealer		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Crew		14. MOTHER'S MAIDEN NAME Howell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-32-7086	
17. INFORMANT Mrs. Amanda Rambo		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 142.0 DUE TO Carcinoma - Left Parotid INTERVAL BETWEEN ONSET AND DEATH 4 mos.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MARCH , 1958, to MAY 26 , 1958, that I last saw the deceased alive on MAY 26 , 1958, and that death occurred at 6:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 97. Hanson St. DATE SIGNED 5-26-58			
ACTUAL SIGNATURE Donald F. Bartley M.D.		PHYSICIAN'S NAME (Type) DONALD F. BARTLEY M.D. Easton, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 28, 1958	
22c. NAME OF CEMETERY OR CREMATORIAL Chester Cem.		22d. LOCATION (City, town, or county) Chestertown, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John W. Wells		24a. REC'D BY REGISTRAR DATE MAY 26 1958	
ADDRESS Chestertown, Md.		24b. REGISTRAR'S SIGNATURE John W. Wells	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Date of Birth

1882-02-16

1882-02-16

1882-02-16

1882-02-16

Name of Deceased
John C. Gandy
John C. Gandy
John C. GandyName of Physician
John C. Gandy
John C. GandyName of Hospital
John C. Gandy
John C. Gandy

1B
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6153

Item 4 File No 230 6-11-58 et

06146

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>	c. LENGTH OF STAY IN 1b <i>P. O. A.</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial Hospital</i>	d. STREET ADDRESS <i>Miles River Neck</i>				
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3. NAME OF REAL NAME - FIRST DECEASED (Type or print) <i>William D. Bradford</i>				
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 9, 1906</i>	9. AGE (in years last birthday) <i>51</i> yrs.	4. DATE OF DEATH <i>May 30, 1958</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Agriculture</i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Unknown</i>	14. MOTHER'S MAIDEN NAME <i>Katie Mae Fleetwood</i>	Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>220-16-7582</i>	17. INFORMANT <i>Mrs. Wm. B. Pippin, wife, Easton, P.D.</i>	INTERVAL BETWEEN ONSET AND DEATH (mo.) <i>sudden</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>823X</i>					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>fracture wrist</i>					
DUE TO (b) <i>fractured 5th left rib</i>					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>Kicked in front seat of car - hit head on a collision car off road into ditch</i>					
20c. TIME OF INJURY Hour a. m. <i>5:00</i> p. m. <i>5/30 1958</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>60. Rte. 340</i>	20f. (City or town) <i>Miles River Neck Rd. Talbot Co.</i>	(County) <i>M.V. Comm.</i>	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Thorston Harrison</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <i>21 Aug 58</i>
22d. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6/2/58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Spring Hill Cemetery</i>	22d. LOCATION (City, town, or county) <i>Easton, Md.</i>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.F. Carroll</i>	ADDRESS <i>Easton, Md.</i>	24a. REC'D BY REGISTRAR <i>DeLoach</i>	24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>	DATE JUN 3 '58	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6154 CERTIFICATE OF DEATH

Reg. Dist. No.

06147

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Caroline</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>3 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Federalsburg, Md. 05X-2</i>		d. STREET ADDRESS <i>rural</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hosp.</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Luna</i>		First	Middle	Lost	4. DATE OF DEATH <i>Grimes</i>	Month	Day	Year	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>December 29 1872</i>	9. AGE (In years lost birthday) <i>85 yrs.</i>	10. UNDER 1 YEAR <input type="checkbox"/> Months <i>4</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>same</i>		11. BIRTHPLACE (State, or foreign country) <i>West Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Edward Hartley</i>		14. MOTHER'S MAIDEN NAME <i>Emily Springer</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT <i>Herbert Springer - Federalsburg, Md.</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		DUE TO <i>Rupture of heart</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		DUE TO <i>Mycocardial Infarct</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>M.D. 2195 Washington St</i>	20f. (City or town) <i>Federalsburg, Md.</i>	(County)	(State)
21. I certify that I attended the deceased from alive on <i>19</i> , to <i>19</i> , that death occurred at <i>2:35A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>2195 Washington St Federalsburg, Md.</i>							
ACTUAL SIGNATURE <i>E.C. H. Schmidt</i>		DATE SIGNED <i>30 May 58</i>							
PHYSICIAN'S NAME (Type) <i>E.C. H. Schmidt</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 1, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Washington Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>St. Michaels, Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herbert Springer - Federalsburg, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>JUN 3 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Albert E. Schuch</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6155

CERTIFICATE OF DEATH

Reg. Dist. No.

06148

1. PLACE OF DEATH a. COUNTY 10160+		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Talbot									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN lb 1hr-50min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tilghman		(Avalon Rd)									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION memorial Hospital		d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)	First Clarence	Middle meredith	Last Harrison	4. DATE OF DEATH 5 - 21 - 1958	Month 5	Day 21	Year 1958								
5. SEX m	6. COLOR OR RACE wh	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/7/90	9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Commercial Fishing		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME James M. Harrison		14. MOTHER'S M AIDEN NAME Emily Whalen		Address											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 420-0		17. INFORMANT Morgan Mrs. William Harrison (wife)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Heart failure Atherosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH							
20a. MEDICAL CERTIFICATION		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Tilghman		(County) None		(State) None	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at <u>4:20 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE E.C. H. Schmidt		M.D. 219 S. Washington St., 22 May 58		ADDRESS (Street, city or town, state)		DATE SIGNED									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 24, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Tilghman Methodist		22d. LOCATION (City, town, or county) Tilghman, Maryland		(State)							
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Moore Tilghman		ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 26 '58		24b. REGISTRAR'S SIGNATURE Audrey									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6156 CERTIFICATE OF DEATH

Reg. Dist. No.

06149

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton.</i>		c. LENGTH OF STAY IN 1b <i>17 days.</i>		b. COUNTY <i>Talbot</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bozman.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <i>Manoria</i>				4. DATE OF DEATH <i>May 30</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>March 31, 1891</i>	
9. AGE (In years lost, birthday) <i>67 yrs.</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. KIND OF BUSINESS OR INDUSTRY <i>unknown</i>		12. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Thomas R. Hunt</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Ferguson.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. 17. INFORMANT <i>unknown Mrs Della Harrison (daughter) Bozman, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO DUE TO (c)				Myocardial failure atherosclerotic coronary heart -			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>obesity, Hypertension, essential hypertension</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>injury</i>			
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5-30</i> , <i>1958</i> , to <i>5-30</i> , <i>1958</i> , that I last saw the deceased alive on <i>5-30</i> , <i>1958</i> , and that death occurred at <i>3:45 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>1000 Rockwood, Bozman, Maryland</i>							
ACTUAL SIGNATURE <i>Henry M. Reeser</i>				DATE SIGNED <i>6-2-58</i>			
PHYSICIAN'S NAME (Type) <i>Henry M. Reeser</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/2/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Bozman Cemetery</i>		22d. LOCATION (City, town, or county) <i>Bozman, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Norman D. Marshall - St. Michael</i>				ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 3 '58	
						24b. REGISTRAR'S SIGNATURE <i>Reeser</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6157 CERTIFICATE OF DEATH

Reg. Dist. No. 06150

1. PLACE OF DEATH a. COUNTY Talbot		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residencia before admission) a. STATE Maryland		b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN lb 25 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 Easton			
d. NAME OF HOSPITAL (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS 318 South Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Margaret Dorothy		First	Middle	4. DATE OF DEATH Jenkins	Month 5	Day 26	Year 1958
5. SEX F		6. COLOR OR RACE WIDOWED <input type="checkbox"/>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/4/04	9. AGE (In years lost, birthday) 53 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done During most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Margaret Jenkins		14. MOTHER'S MAIDEN NAME Verzetter Clark		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Stella Ockinerry Cousin		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 525X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PUE TO cause undetermined		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 8:45 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE E.C.H. Schmidt		22. DATE OF INJURY Month, Doy, Year Hour a.m. 19 p.m.		23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 24. (City or town) (County) (State)		ADDRESS (Street, city or town, state) 219 S. Washington St 27 May 58 Easton, Maryland	
25. BURIAL, CREMATION, REMOVAL (Specify) Burial		26. DATE THEREOF 5/31/58		27. NAME OF CEMETERY OR CREMATORIAL Richards Cem.		28. LOCATION (City, town, or county) Easton (State)	
29. FUNERAL DIRECTOR'S SIGNATURE James H. Schmidt, Easton, Md.		30. ADDRESS James H. Schmidt, Easton, Md.		31. REC'D BY REGISTRAR MAY 29 '58		32. REGISTRAR'S SIGNATURE James H. Schmidt	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	990	991	992	993	994	995	996	997	998	999	1000
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

80

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2

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6158 CERTIFICATE OF DEATH

Reg. Dist. No.

06153

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution/Residence before admission) a. STATE									
Talbot MARYLAND		MARYLAND b. COUNTY									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 1 hr. 45 min									
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS Harklock 09x-2									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First John	Middle Wesley								
4. DATE OF DEATH		Month MAY	Day 7								
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) 89 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME John Thompson		14. MOTHER'S MAIDEN NAME Jane Lake		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.					
17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 260x Diabetes mellitus		20c. TIME OF INJURY Month, Doy, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, and that death occurred at 9:00 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE E. C. H. Schmidt		ADDRESS (Street, city or town, state) 219 W. Washington St. 7 May 58		DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 10, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Washington Cemetery		22d. LOCATION (City, town, or county) Hurlock		(State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Trampot & Son, Federalsburg, Md.		ADDRESS		24a. REC'D BY REGISTRAR MAY 13 '58		24b. REGISTRAR'S SIGNATURE A. M. Edin					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6159 CERTIFICATE OF DEATH

Reg. Dist. No. **06154**

1. PLACE OF DEATH a. COUNTY Talbot		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN 1b 3 days.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 545-560 Queen St. Easton, Md.	
3. NAME OF DECEASED (Type or print) Blanche		First I	Middle da
4. DATE OF DEATH Month May Day 28 Year 1958		Lost	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 4, 1905
9. AGE (In years lost birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph E. Bettos	
14. MOTHER'S MAIDEN NAME Elizabeth Peachbloom		15. WAS DECEASED EVER IN U. S. ARMED FORCES? No (If yes, give rank or dates of service) NO	
16. SOCIAL SECURITY NO. unknown		17. INFORMANT 9 Elmwood Laramore (Husband) Easton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		19. INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Cerebral edema			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Heart failure (c) Myocardial scarring			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____, from the causes and on the date stated above.			
ACTUAL SIGNATURE C. H. Schmidt		ADDRESS (Street, city or town, state) 219 S. Washington St. 28 Nov 58	
PHYSICIAN'S NAME (Type) E. C. H. Schmidt		DATE SIGNED 28 Nov 58	
22a. BURIAL, CREMATION, REMOVAL (Specify) 5/30/58		22b. DATE THEREOF 5/30/58	
22c. NAME OF CEMETERY OR CREMATORIAL Spring Hill Cemetery		22d. LOCATION (City, town, or county) Easton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Franklin Carroll		24a. REC'D BY REGISTRAR JUN 2 '58	
ADDRESS EASTON, Md.		24b. REGISTRAR'S SIGNATURE W. Franklin Carroll	

CERTIFICATE OF DEATH

CHILD'S NAME

NAME OF PARENT

MATERIAL TESTED

NAME

TEST NUMBER

MANITOBA STATE DEPARTMENT OF HEALTH - 8 VOLUME 18

TEST NUMBER

TEST NUMBER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6160 CERTIFICATE OF DEATH

Reg. Dist. No.

06155

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE North Carolina b. COUNTY DARE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easton Memorial Hosp.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MANTO 70 x -3	
3. NAME OF DECEASED (Type or print) First Guy H. Lennon		4. DATE OF DEATH Month May Day 29 Year 1958	
5. SEX Male 6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> June 23 1896	
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Retail	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William P. Lennon		14. MOTHER'S MAIDEN NAME Garet Elthridge	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WWI		16. SOCIAL SECURITY NO. UNKNOWN 17. INFORMANT Dr. William S. Lennon	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 165x DUE TO Concurrence of lung, right INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 219 S. Washington St. (County) 29 May 58 (State)	
21. I certify that I attended the deceased from 19 to 19 , that I last saw the deceased alive on 19 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE E. C. H. Schmidt		ADDRESS (Street, city or town, state) 219 S. Washington St. 29 May 58 DATE SIGNED	
PHYSICIAN'S NAME (Type) E. C. H. Schmidt		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF MAY 31, 1958 22c. NAME OF CEMETERY OR CREMATORIUM MANTO CEMETERY 22d. LOCATION (City, town, or county) MANTO, NORTH CAROLINA (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. FRAMPTON & SON, FEDERALSBURG, MD.		ADDRESS JUN 9 '58 24a. REC'D BY REGISTRAR Alt. Search 24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6161 CERTIFICATE OF DEATH

06156

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>TALBOT</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <i>Maryland</i>	b. COUNTY <i>TALBOT</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EASTON.</i>	c. LENGTH OF STAY IN 1b <i>7 hrs. 50 min.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Clayborne, Md.</i>	d. STREET ADDRESS				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>EASTON Memorial Hosp.</i>		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>George</i>	Middle <i>Albert</i>	Last <i>Lindsay</i>	4. DATE OF DEATH <i>May 30 1958</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 15 1891</i>	9. AGE (In years lost birthday) <i>66 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. Year Hours <i>58</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Unknown</i>	10c. BIRTHPLACE (State or foreign country) <i>Maryland.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>				
13. FATHER'S NAME <i>George Lindsay Sr.</i>	14. MOTHER'S MAIDEN NAME <i>Annie M. Rogers</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) <i>Unknown</i>	16. SOCIAL SECURITY NO. <i>4220-07-8270</i>	17. INFORMANT <i>Helen M. Lewis, daughter, same</i>	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>465x</i>				<i>Pulmonary thromboar</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Myocardial infarction</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Elkhardt</i>	(County) (State) <i>St. Michaels. Md.</i>			
21. I certify that I attended the deceased from <i>19</i> , 19 <i>58</i> , to <i>19</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>19</i> , 19 <i>58</i> , and that death occurred at <i>8A M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>E. C. H. Schmidt</i>	ADDRESS (Street, city or town, state) <i>219 S. Washington St. 30 May 58</i>			DATE SIGNED <i>30 May 58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>May 22, 1958</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Clint Cemetery</i>	22d. LOCATION (City, town, or county) <i>St. Michaels. Md.</i>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hamilton Garrison St. Michaels, Md.</i>	ADDRESS	24a. REG'D BY REGISTRAR <i>JUN 6 1958</i>	24b. REGISTRAR'S SIGNATURE <i>W. E. Cook</i>				

CERTIFICATE OF DEATH

Date of Birth

Name of Deceased

Name of Physician

Date of Death

Cause of Death

Name of Hospital

Name of Doctor

Name of Hospital

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-travel permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6162 CERTIFICATE OF DEATH

06158

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton Md</u>		c. LENGTH OF STAY IN 1b <u>9 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trappe</u>	
3. NAME OF DECEASED (Type or print) <u>Baby</u>		First <u>Baby</u>	Middle <u>Boy</u>
4. SEX <u>M</u>		5. COLOR OR RACE <u>C01</u>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
7. DATE OF BIRTH		8. DATE OF DEATH <u>May 18 1958</u>	
9. AGE (In years last birthday) <u>1 yr.</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Memorial Hosp. Easton Md. U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>Address</u>	
13. FATHER'S NAME <u>Paul Middleton</u>		14. MOTHER'S MAIDEN NAME <u>Sylvia Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Paul S Middleton Father</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776 x Prematurity</u> WT-2-7 Length-73 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO cause (a), stating the under- lying cause last. (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>9 hrs</u>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>518</u>		20f. (City or town) (County) (State) <u>Easton Md</u>	
21. I certify that I attended the deceased from <u>5/8</u> , 19 <u>58</u> , to <u>5/9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5/9/58</u> , 19 <u>58</u> , and that death occurred at <u>6:50 AM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>L. J. Eglseid</u> M.D. ADDRESS (Street, city or town, state) <u>Easton Md</u> DATE SIGNED			
22a. BURIAL CREMATION REMOVAL (Specify) <u>Incineration</u>		22b. DATE THEREOF <u>5/11/58</u>	
22c. NAME OF CEMETERY OR CREMATORIUM <u>Memorial Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. J. Eglseid</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 20 '58</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Alvin E. Eglseid</u>	

CERTIFICATE OF DEATH

FD-204 (Rev. 5-25-64)

NAME OF DECEASED		NAME OF DEATH CERTIFYING PHYSICIAN	
John Doe		Dr. John Doe	
Age: 65		Place of Death: Hospital Room 102	
Sex: Male		Date of Death: April 15, 1968	
Race: White		Time of Death: 11:00 AM	
Occupation: Retired		Cause of Death: Heart Failure	
Address: 123 Main Street		Name of Hospital: St. Mary's Hospital	
City: Baltimore		County: Baltimore	
State: Maryland		Signature of Physician	
		Dr. John Doe	
		S.S. No. 123-45-6789	
		Date: April 16, 1968	

FD-204 (Rev. 5-25-64) 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6163

CERTIFICATE OF DEATH

Reg. Dist. No. 06157

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>12 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. STREET ADDRESS <u>X Trappe</u>	
3. NAME OF DECEASED (Type or print) <u>Wayne Ronald Middleton</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. SEX <u>M</u>	5. COLOR OR RACE <u>Col</u>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	7. B. DATE OF BIRTH <u>5/8/58</u>
8. WIDOWED <input type="checkbox"/>	9. DIVORCED <input type="checkbox"/>	10. AGE (In years, months, days, hours, minutes) lost birthday <u>10 months</u>	11. IF UNDER 1 YEAR Months <u>10</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u> </u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Paul Middleton</u>		14. MOTHER'S MAIDEN NAME <u>Sylvia Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>776X</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Paul E. Middleton Jr.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u> </u>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that I attended the deceased from <u>5/8</u> , 19 <u>58</u> , to <u>5/20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5/19</u> , 19 <u>58</u> , and that death occurred at <u>5:20 AM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>J. J. Eglseder</u> PHYSICIAN'S NAME (Type) <u>J. J. Eglseder</u>		ADDRESS (Street, city or town, state) <u>12 W. Hayes St. Easton Md</u> DATE SIGNED <u>5/29/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Memorials</u>		22b. DATE THEREOF <u>5/21/58</u>	
22c. NAME OF CEMETERY OR CREMATORIAL <u>Memorial Trap</u>		22d. LOCATION (City, town, or county) <u>Trappe</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Body is unclaimed</u>		24a. REC'D BY REGISTRAR DATE JUN 2 '58	
24b. REGISTRAR'S SIGNATURE <u>W. couch</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8.9 File G231 7-7-58 et

6175 CERTIFICATE OF DEATH

Reg. Dist. No.

06159

1. PLACE OF DEATH a. COUNTY Talbot		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxford		b. COUNTY Talbot	
c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxford	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Market St.		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Sarah	First A.	Middle Queen	4. DATE OF DEATH Month 5 Day 28 Year 1958
5. SEX Female	6. COLOR OR RACE Col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/10/71 1877
9. AGE (In years last birthday) 80 75 yrs.		9. AGE (In years last birthday) 80 75 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gilbert Adams		14. MOTHER'S MAIDEN NAME Tillie Cox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) XX		16. SOCIAL SECURITY NO. 212-07-3711-B, Isaac Queen.)	
17. INFORMANT XXX		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Cerebral Thrombosis INTERVAL BETWEEN ONSET AND DEATH acute	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Cerebral Arterio-clerotic Disease 3-4 months		(c) Generalized Arteriesclerosis —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-28 , 19 58 , to 5/28 , 19 58 , that I last saw the deceased alive on 5/26 , 19 58 , and that death occurred at 2 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 12 N. Harrison St. DATE SIGNED 5/28/58			
ACTUAL SIGNATURE L. J. Eglseeder		M.D. 12 N. Harrison St.	
PHYSICIAN'S NAME (Type) L. J. Eglseeder		EASTON, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/31/58	
22c. NAME OF CEMETERY OR CREMATORIAL Johnwestly Gem		22d. LOCATION (City, town, or county) Oxford (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Dashiell		ADDRESS Easton, Md.	
24a. REC'D BY REGISTRAR DATE JUN 5 '58		24b. REGISTRAR'S SIGNATURE Albert Beach	

СЕРИЯ ОБРАЩЕНИЙ

СЕРИЯ ОБРАЩЕНИЙ

СЕРИЯ ОБРАЩЕНИЙ



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by a hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6176 CERTIFICATE OF DEATH

Reg. Dist. No.

06160

1. PLACE OF DEATH a. COUNTY Talbot		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural-Easton		c. LENGTH OF STAY IN lb 20 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural-Easton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Timberlane Farm				d. STREET ADDRESS Timberlane Farm		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First William	Middle Nolan	Last Rambo	4. DATE OF DEATH May 4 1958	Month May	Day 4	Year 1958
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1889	9. AGE (In years last birthday) 68 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. HOURS 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jaywood Rambo		14. MOTHER'S MAIDEN NAME Josephine Middleton					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Marie Rambo, Easton, RD, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0		450.0		Quenupm Circi Willis		INTERVAL BETWEEN ONSET AND DEATH Sudden	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b)		Asteris adenosis		3-4 years	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-7-54 , 19 58 , to May 4 , 19 58 , that I last saw the deceased alive on 4-21 , 19 58 , and that death occurred at 8 AM , from the causes and on the date stated above. ACTUAL SIGNATURE William L. Winters		M.D.		ADDRESS (Street, city or town, state) 2103 Dover Easton Md 21801		DATE SIGNED 5/7/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/7/58		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Woodlawn Memorial Park		22d. LOCATION (City, town, or county) (State) Easton, Rd, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Frumpton Carroll				24a. REC'D BY REGISTRAR Alt. Resnick		24b. REGISTRAR'S SIGNATURE	
				DATE MAY 6 '58			

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6164 CERTIFICATE OF DEATH

Reg. Dist. No.

06161

1. PLACE OF DEATH a. COUNTY Talbot		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 Easton		d. STREET ADDRESS 411 North St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 411 North St.						e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DOROTHY		First E.	Middle SATCHELL	Lost	4. DATE OF DEATH May 24,	Month 19 58	Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 21, 1917	9. AGE (In years lost birthday) 40 yrs.	10. IF UNDER 1 YEAR Months 40	11. IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles F. Perry		14. MOTHER'S MAIDEN NAME Emma Patrick					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Lawrence Satchell		Address Easton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Cervix						INTERVAL BETWEEN ONSET AND DEATH 7 mos.	
171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from NOV. 1957 , to MAY 24, 1958 , that I last saw the deceased alive on MAY 24, 1958 , and that death occurred at 6:30 A.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 9 N. HANSON ST.	
ACTUAL SIGNATURE Donald F. Bartley M.D.						DATE SIGNED 5-24-58	
PHYSICIAN'S NAME (Type) DONALD F. BARTLEY M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 27, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Spring Hill Cemetery		22d. LOCATION (City, town, or county) Easton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son		ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DATE JUN 2 '58		24b. REGISTRAR'S SIGNATURE W. E. Newnam	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be deferred for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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2000-01

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PROBLEMS

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12

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6177 CERTIFICATE OF DEATH

06162

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Talbot MARYLAND		Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels		c. LENGTH OF STAY IN 1b 5 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION — — — —		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McDaniel, Md.	
3. NAME OF DECEASED (Type or print)		First BENJAMIN	Middle FRANKLIN
3. NAME OF DECEASED (Type or print)		Last SHERMAN	4. DATE OF DEATH Month May Day 24, Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 27, 1892
9. AGE (In years lost birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Trans. Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Transportation	
10b. KIND OF BUSINESS OR INDUSTRY Transportation		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Franklin Sherman	
14. MOTHER'S MAIDEN NAME Ida G. Gammell		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. 214-05-1030		17. INFORMANT Mrs. B. Frank Sherman, McDaniel, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) atherosclerotic coronary (c) artery d		INTERVAL BETWEEN ONSET AND DEATH —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED White of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5-24-1958 to 5-24-1958 that I last saw the deceased alive on 5-24-1958, and that death occurred at 8 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) McDaniel, Md.	
ACTUAL SIGNATURE Guy M. Prester		DATE SIGNED 5-26-58	
PHYSICIAN'S NAME (Type) Burial		22c. NAME OF CEMETERY OR CREMATORIAL REMOVAL (Specify) East New Market Gem.	
22d. LOCATION (City, town, or county) East New Market, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE S. Hampton Harrison, St. Michaels, Md.		24a. REC'D BY REGISTRAR DATE MAY 29 '58	
24b. REGISTRAR'S SIGNATURE A. L. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Social

Date

Place

Cause

Time

Age

Sex

Race

Color

Religion

Occupation

Manner

Residence

Cause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6165 CERTIFICATE OF DEATH

Reg. Dist. No.

06163

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 40 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTON Memorial Hosp.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON 05 x-2	
3. NAME OF DECEASED (Type or print) First Cooper Middle C. Last Smith		d. STREET ADDRESS 7101	
4. DATE OF DEATH 5 - 24		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 2 1901	
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clarence M. Smith		14. MOTHER'S MAIDEN NAME McEvilia J. Wiley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Mrs. Willie Bell Austin, sister -	
17. INFORMANT Unknown		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 430.1 DUE TO Myocardial Infarct Conditions, if any, which gave rise to immediate cause (a), stating the under- (b) lying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 10:25 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE E.C. H. Schmidt		ADDRESS (Street, city or town, state) 219 S Washington St. 24 May 58 DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-26-58	
22c. NAME OF CEMETERY OR CREMATORIAL Cambridge Cemetery		22d. LOCATION (City, town, or county) Cambridge, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service Cambridge 14		24a. REC'D BY REGISTRAR DATE MAY 28 '58	
		24b. REGISTRAR'S SIGNATURE Albert LeCompte	

DEPARTMENT OF HEALTH - SANITATION, 19

CERTIFICATE OF DEATH

Tom - I believe
was 20 years old

Original
Signature
Thunder H. C. I.

applies to our new 2 PIC
test all of us. S

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6166 CERTIFICATE OF DEATH

Reg. Dist. No.

06164

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>3 days.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St. Michaels</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>				d. STREET ADDRESS <i>Talbot Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Baby</i>	Middle <i>Girl</i>	Last <i>Stewart</i>	4. DATE OF DEATH <i>May 31 1958</i>	Month Day Year	Day	Year
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 28 1958</i>	9. AGE (In years last birthday) yrs. <i>3</i>	IF UNDER 1 YEAR Months <i>3</i>	IF UNDER 24 HRS. Days Hours Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>W Maynard Stewart</i>		14. MOTHER'S MAIDEN NAME <i>Doris Brewster</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>M W Maynard Stewart (Father)</i>		Address <i>22 Bay</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prematurity</i> DUE TO 776X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5-28-58</i> to <i>5-31-58</i> , that I last saw the deceased alive on <i>5-31-58</i> , and that death occurred at <i>7:50 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>St. Michaels Md</i> DATE SIGNED <i>6-2-58</i>							
ACTUAL SIGNATURE <i>Maynard Stewart</i>		M.D.					
PHYSICIAN'S NAME (Type) <i>Doris M. Brewster</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>6/3/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Memorial Hospital</i>		22d. LOCATION (City, town, or county) (State) <i>Easton Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 5 '58		24b. REGISTRAR'S SIGNATURE <i>Or. Leach</i>	

M
C
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6167 CERTIFICATE OF DEATH

Reg. Dist. No. **06165**

1. PLACE OF DEATH a. COUNTY TALBOT		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 1 hrs - 15 am	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTON Memorial Hosp.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels	
3. NAME OF DECEASED (Type or print) Baby Boy		d. STREET ADDRESS None	
4. DATE OF DEATH May 29		Month May	Day 29
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 28 - 1958	
9. AGE (In years (last birthday) yrs. 1		10. UNDER 1 YEAR IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME W. Maynard Stewart		14. MOTHER'S MAIDEN NAME Doris Brewster	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Maynard Stewart		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO 776X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-28-58 to 5-29-58 , that I last saw the deceased alive on 5-29-58 , and that death occurred at 7:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) St. Michaels Md		DATE SIGNED 6-2-58	
ACTUAL SIGNATURE Henry M. Reeder		M.D.	
PHYSICIAN'S NAME (Type) Henry M. Reeder			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 6/1/58		22b. DATE THEREOF 6/1/58	
22c. NAME OF CEMETERY OR CREMATORIAL Memorial Hospital		22d. LOCATION (City, town, or county) EASTON MD (State) None	
23. FUNERAL DIRECTOR'S SIGNATURE Henry M. Reeder		24a. REC'D BY REGISTRAR DATE JUN 3 1958	
		24b. REGISTRAR'S SIGNATURE W. E. Schuck	

CERTIFICATE OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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16166

Reg. Dist. No.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6168 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Dorchester</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>10 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hurlock</i>		d. STREET ADDRESS <i>No 1</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hosp</i>				d. STREET ADDRESS <i>No 1</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Milton</i>		First <i>Guy</i>	Middle <i></i>	Last <i>Trice</i>	4. DATE OF DEATH <i>May 23 1958</i>	Month <i>May</i>	Day <i>23</i>	Year <i>1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 25, 1886</i>	9. AGE (In years lost birthday) <i>71 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Former</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>John Trice</i>		14. MOTHER'S MAIDEN NAME <i>Lillie Mae Parker</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>918 00 0000</i>		17. INFORMANT <i>Mrs. Lillie Trice (wife)</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		DUE TO <i>Coronary all myocardic heart disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Washington Cemetery</i>		20f. (City or town) <i>Hurlock</i>	(County) <i></i>	(State) <i></i>
21. I certify that I attended the deceased from <i>5/13</i> , 1958, to <i>5/23</i> , 1958, that I last saw the deceased alive on <i>5/22</i> , 1958, and that death occurred at <i>2 AM</i> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Thurston Harrison</i>		M.D.		ADDRESS (Street, city or town, state) <i>Carson Hwy Land</i>		DATE SIGNED <i>28 May 58</i>		
PHYSICIAN'S NAME (Type) <i>THURSTON HARRISON</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>5/25/58</i>		22b. DATE THEREOF <i>5/25/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Washington Cemetery</i>		22d. LOCATION (City, town, or county) <i>Hurlock</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ruth S. Hollingsby</i>		ADDRESS <i>East New Market, Md</i>		24a. REC'D. BY REGISTRAR <i>MAY 29 1958</i>		24b. REGISTRAR'S SIGNATURE <i>Alt. couch</i>		

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6169 CERTIFICATE OF DEATH

Reg. Dist. No. 06167

1. PLACE OF DEATH a. COUNTY TALBOT		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 17 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTON Memorial Hosp.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Claiborne	
3. NAME OF DECEASED (Type or print) Ethel		d. STREET ADDRESS None	
5. SEX Fe		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH April 14, 1909		9. AGE (in years last birthday) 49 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Jefferson		14. MOTHER'S MAREN NAME Emma Kroskey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. no given	
17. INFORMANT Mr. James West (husb)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 150x DUE TO metastatic carcinoma of Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO the abdomen (c)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, and that death occurred at 11 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Elkhorn		ADDRESS (Street, city or town, state) 219 S. Washington St 14 May 58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/16/58	
22c. NAME OF CEMETERY OR CREMATORIUM Springfield Cemetery		22d. LOCATION (City, town, or county) Easton	
23. FUNERAL DIRECTOR'S SIGNATURE S. Hamilton Harrison, A. Michael		24a. REC'D BY REGISTRAR DATE MAY 20 '58	
24b. REGISTRAR'S SIGNATURE Aut. 15			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6170 CERTIFICATE OF DEATH

06168

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>30 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i> 40	
3. NAME OF DECEASED (Type or print) <i>Charles E</i>		d. STREET ADDRESS <i>48 Flood Ave.</i>	
4. DATE OF DEATH <i>5 - 11 - 1958</i>	Month	Day	Year
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/23/78</i>
9. AGE (In years lost last birthday) <i>80 yrs.</i>		10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
13. FATHER'S NAME <i>Ernest Hanks</i>		14. MOTHER'S MAIDEN NAME <i>Rachel Anne Wilson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Sisterde Lysis (daughter)</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>465x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO <i>Pulmonary embolism</i> <i>generalized leg leg</i> <i>seizure</i>	
19. WAS AUTOPSY PERFORMED? <i>Yes</i> <input checked="" type="checkbox"/> <i>No</i> <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at <i>8:45 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>2195 Washington 12 May 58</i>	
ACTUAL SIGNATURE <i>E.C.H. Schmidt</i>		DATE SIGNED <i>16 May 58</i>	
PHYSICIAN'S NAME (Type) <i>E.C.H. Schmidt</i>		22a. BURIAL-CREMATION, REMOVAL (Specify) <i>5/14/58</i>	
22b. DATE THEREOF <i>5/14/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Brarpe Cemetery</i>	
22d. LOCATION (City, town, or county) <i>Brarpe Md</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James B. Donnell, Easton, Md.</i>		24a. REC'D BY REGISTRAR DATE MAY 15 '58	
ADDRESS <i>James B. Donnell, Easton, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Asheen</i>	

CERTIFICATE OF DEATH

Date of Birth

Sex

Race

Name

Date of Death

Name
of
Hospital

Name of Physician

Age

Name
of
Physician

Name of Hospital

Age

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6171 CERTIFICATE OF DEATH

Reg. Dist. No. 06169

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>6 hrs 40 mins</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		e. STREET ADDRESS <i>05x-2</i>	
3. NAME OF DECEASED (Type or print) <i>Jerome</i>		First <i>Jerome</i>	Middle <i>Merritt</i>
4. DATE OF DEATH <i>5-19-1958</i>		Lost <i>5</i>	Month <i>5</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>wh</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>10/20/92</i>		9. AGE (In years by birthday) <i>65</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>65</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman - Farmer Insurance</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Agent</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Jerome H. Woodward</i>	
14. MOTHER'S MAIDEN NAME <i>Mary Elizabeth Fluharty</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>947-00-1234</i>		17. INFORMANT <i>Not given Mrs. Betty Pleasanton (daughter)</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>526x</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Pulmonary Edema</i> <i>Bronchictasis</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3/19</i> , 19 <i>58</i> , to <i>3/19</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>3/19</i> , 19 <i>58</i> , and that death occurred at <i>Easton</i> , MD, from the causes and on the date stated above. ACTUAL SIGNATURE <i>P. E. Cox</i>		ADDRESS (Street, city or town, state) <i>Easton, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/23/58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Greensboro</i>		22d. LOCATION (City, town, or county) <i>Greensboro, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Boulael</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 21 '58</i>	
24b. REGISTRAR'S SIGNATURE <i>Allesrich</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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